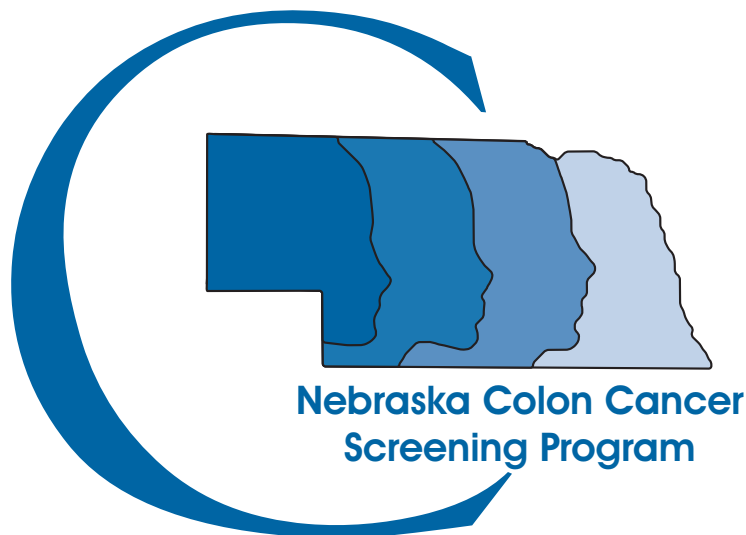


*Fecal Occult
Blood Test Kit*

**Colon
Health
Screening
Exams**

Colonoscopy



CLIENT INFORMATION BOOKLET

**In this booklet you will find information on how
Nebraska Colon Cancer Screening Program can serve you.**



**Nebraska Department of Health and Human Services
Nebraska Colon Cancer Screening Program
301 Centennial Mall South - P.O. Box 94817
Lincoln, NE 68509-4817**

Toll Free: 1-800-532-2227

Fax: 402-471-0913

E-mail: ncp@dhhs.ne.gov

Website: www.dhhs.ne.gov/crc

What is the Nebraska Colon Cancer Screening Program (NCP)?

NCP is the newest program added to the Office of Women's and Men's Health. Nebraska is one of only five such programs in the nation. The goal of NCP is to increase screening for colon cancer and to decrease the number of Nebraskan's who are diagnosed and die from colon cancer.

This program is what we call a Demonstration Program! This means that research is being done to see if this type of program works. In order to carry out the program there are strict eligibility guidelines based on personal and family history. Not everyone who completes an enrollment form will be eligible.

As a client of NCP, you have access to quality health care services, education, and information to help you make healthy lifestyle choices for personal wellness.

NCP offers the following tests if you meet the strict eligibility guidelines:

- Fecal Occult Blood Test (FOBT)
- Colonoscopy

Men and women over the age of 50 are eligible to complete an enrollment form. To find out if you are eligible for the program, you must:

- Fill out an Enrollment Form, Colorectal Health History form; and
- Sign a Release of Medical Information.

A man or woman may be eligible for the NCP if:

- He / She is 50 years of age and older;
- He / She is within the income guidelines (the income guidelines change every year in July).
- He/She can be on Medicare, Medicaid and have insurance. *(If client has a Health Maintenance Organization (HMO) insurance they are not eligible for the NCP)*

For questions regarding the NCP, call **1-800-532-2227** Monday through Friday from 8:00 a.m. to 5:00 p.m. (Central Standard Time) or you can e-mail us at ncp@dhhs.ne.gov.

You must complete an enrollment form each year.

Enclosed in this packet you have received:

- Booklet:
 - Steps on How to Use the Program
 - Notice of Information Privacy Practices
 - Colon Cancer Screening Guidelines
 - Colon Cancer Terms and Definitions
 - Informed Consent and Release of Medical Information (for you to keep)
 - Enrollment Form for any person who is 50+ and meets program eligibility guidelines
- Postage Paid Envelope

What Steps Do I Take?

1. ☐ Read, complete, and sign the Enrollment Form, Colon Health History and Release of Medical Information located in the back of this booklet.
2. ☐ Mail the following information in the postage-paid envelope:
 - ☐ Your **completed** Enrollment Form, Colon Health History, and **signed** Release of Medical Information.

The Nebraska Colon Cancer Screening Program will use your Colon Health History to determine your eligibility to participate. The NCP has strict eligibility guidelines.

Once the program has determined your eligibility, you will receive information by mail.

If you need more enrollment forms for others in your home or friends or family that are over 50 or if you have any questions please call us at **1-800-532-2227** or you can e-mail us at ncp@dhhs.ne.gov.

Colon Cancer Terms and Definitions

Anus - The opening of the rectum to the outside of the body.

Cancer - A disease in which cells grow out of control. Cancer cells can invade nearby tissue and spread to other parts of the body.

Colon - The long, coiled, tube-like organ (also known as large bowel or large intestine) that removes water from digested food. The remaining material, solid waste called “stool,” moves through the colon and the rectum and leaves the body through the anus. Parts of the colon include: cecum, ascending colon, transverse colon, descending colon, and sigmoid colon. The average colon is approximately 6 feet long.

Colonoscope - A flexible, lighted instrument with a built-in tiny camera used to view the inside of the entire colon and rectum.

Colonoscopy - Before this test, you will take a strong laxative to clean out the colon. Colonoscopy is conducted in a doctor’s office, clinic, or hospital. You are given a sedative to make you more comfortable, while the doctor uses a narrow, flexible, lighted tube to look inside the rectum and the entire colon. During the exam, the doctor may remove some polyps and collect samples of tissue or cells for more testing. This test is recommended every 10 years.

Colorectal - Related to the colon, rectum, or both.

Crohn’s Disease - Crohn’s disease is an ongoing disorder that causes inflammation of the digestive tract, also referred to as the gastrointestinal (GI) tract.

Double-Contrast Barium Enema - This test is conducted in a radiology center or hospital. Before the test, you use a strong laxative and/or enema to clean out the colon. This procedure involves taking x-rays of the rectum and colon after you are given an enema with a barium solution, followed by an injection of air. The barium coats the lining of the intestines so that polyps and other abnormalities are visible on the x-ray. This test is recommended every 5 years.

Familial Adenomatous Polyposis (FAP) - **Familial** means that it runs in families. Each child of an affected parent has a 50% risk of inheriting the disease gene. **Adenomatous** is a type of mushroom-shaped growth or polyp, which may be precancerous. **Polyposis** is a condition where 100 or more polyps can form in the large intestines.

Fecal Occult Blood Test (FOBT) – A test that checks for hidden blood in the stool. At home, using a small stick from a test kit, you place a small amount of your stool, from three different bowel movements three days in a row, on test cards. You return the cards to your doctor’s office or a lab, where they’re checked for blood. This test is recommended yearly. If blood is found, you will need a follow-up colonoscopy.

First (1st) Degree relative - Parents, brothers, sisters, or children

Flexible Sigmoidoscopy – Before this test, you use a strong laxative and/or enema to clean out the colon. Flexible sigmoidoscopy is conducted at the doctor’s office, clinic, or hospital. The doctor uses a narrow, flexible, lighted tube to look at the inside of the rectum and the lower portion of the colon. During the exam, the doctor may remove some polyps (abnormal growths) and collect samples of tissue or cells for more testing. This test is recommended every 5 years. If polyps are found, you will need a follow-up colonoscopy.

Gastroenterologist - A doctor who specializes in diagnosing and treating disorders of the digestive system (which includes the esophagus, stomach, pancreas, intestines, and liver).

Colon Cancer Terms and Definitions

Gastrointestinal Tract - The part of the digestive tract where the body processes food and eliminates waste. It includes the esophagus, stomach, liver, intestines, and rectum.

Hereditary Non Polyposis Colorectal Cancer (HNPCC) - Also known as the Lynch syndrome, is an inherited cause of cancer of the bowel.

Inflammatory Bowel Disease (IBD) - Inflammatory bowel disease is the name of a group of disorders that cause the intestines to become inflamed (red and swollen).

Intestine - The long, tube-shaped organ in the abdomen, also called the “bowel”, that completes the process of digestion. There are both a large and small intestine.

Polyp - An abnormal, often precancerous growth of tissue (colorectal polyps are growths of tissue inside the intestine).

Rectum - The last 8 to 10 inches of the large intestine. The rectum stores solid waste until it leaves the body through the anus.

Screening Test - “Screening tests” are tests used to check, or screen, for disease when there are no symptoms. Screening tests for colorectal cancer include: fecal occult blood test, flexible sigmoidoscopy, colonoscopy, and double contrast barium enema. (When a test is performed to find out why symptoms exist, it is called a “diagnostic” test).

Sigmoidoscope - A flexible, lighted instrument with a built-in tiny camera that allows the doctor to view the lining of the rectum and lower portion of the colon.

Stool - The waste matter discharged in a bowel movement; feces.

Stool Test - A test to check for hidden blood in the bowel movement (also see Fecal Occult Blood Test).

Sources for definitions: National Cancer Institute and Centers for Disease Control and Prevention.

Notice of Information Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. Effective: 4/14/03

Contact Information

The Department of Health and Human Services of the State of Nebraska, and those Agencies inclusive of health care facilities and medical assistance programs that are affiliated under the common control of the Nebraska Partnership for Health and Human Services Act, are required by federal law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information. This notice fulfills the "Notice" requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Privacy Rule. If you have questions about any part of this Notice of Information Privacy practices or desire to have further information concerning information practices at the State of Nebraska, Department of Health and Human Services please direct them to: The HIPAA Privacy & Security Office, 301 Centennial Mall South - 5th Floor, PO Box 95026, Lincoln, Nebraska 68509-5026. By e-mail to hipaa.office@dhhs.ne.gov.

This Notice of Information Privacy Practices explains how the State of Nebraska, Department of Health and Human Services affiliated agencies, medical assistance programs, and care facilities, will use or disclose your Protected Health Information for the purposes of diagnosis, treatment, obtaining payment for your health care bills, or to conduct healthcare operations. Protected Health Information includes records, notes, and reports, diagnostic films, claims, etc. that are individually identifiable. The Department of Health and Human Services (DHHS) engages in the following practices involving the use and disclosure of Individually Identifiable Health Information to carry out treatment, payment, and health care operations:

For Treatment: We may use your medical information to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other health care personnel who are involved in your treatment. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that appropriate meals can be prepared. Different agencies within DHHS also may share your medical information in order to coordinate the different things you need, or to support and maintain your continuum of care as you are transferred to facilities within DHHS. We also may disclose medical information about you to people outside the treatment facility who may be involved with your medical care.

Emergencies: We may use or disclose your Protected Health Information in an emergency treatment situation. If this happens, your physician will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physician, or another physician in the practice, is required by law to treat you and the physician has attempted to obtain your consent but is unsuccessful, he or she may still use or disclose your Protected Health Information to treat you.

For Payment: We may use and disclose your medical information so that the treatment and services you receive at a treatment facility may be billed; also, so that payment may be collected from you, an insurance company, or a third party. For example, we may use your medical information from a surgery you received at the hospital so that the hospital can be reimbursed. We may also use your information to obtain prior approval for a treatment you may receive, or, to determine whether a third party will cover the treatment.

For Health Care Operations: We may use and disclose medical information about you for medical operations. These uses and disclosures are necessary to make sure all patients receive quality care. For example, we may use medical information to review your treatment and services and to evaluate the performance of the staff which cares for you. We may also combine medical information about many patients to decide what additional services should be covered, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other hospital personnel for review and learning purposes.

We may also combine the medical information we have with medical information from other health plans to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identity of the patients.

Certain incidental disclosures of Protected Health Information cannot be avoided. For example, information may be exposed when a physician is discussing treatment options or a procedure with a clinician at a nurse station for a member at a Veterans Home. Another member or a visitor could easily overhear this conversation. Since the "environment of care" specific to this type of facility is an open residential environment, this disclosure of health information would be considered "incidental" and would occur within the standard operations for the established environment of care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization, or Opportunity to Object for Purposes Other Than Treatment, Payment, or Health Care Operations

The State of Nebraska Health and Human Services is permitted to make the following uses and disclosures of Individually Identifiable Health Information should circumstances warrant such uses and disclosures:

Required By Law: We may use or disclose your Protected Health Information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your Protected Health Information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purposes of preventing or controlling disease, injury, or disability, or for the purposes of conducting public health surveillance, public health investigations, and public health interventions. We may also disclose your Protected Health Information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your Protected Health Information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose Protected Health Information to a health oversight agency for activities authorized by law, including audits, investigations, and inspections; licensure or disciplinary actions; civil, administrative or criminal proceedings or actions; or other activities necessary for appropriate oversight of the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

Abuse or Neglect: We may disclose your Protected Health Information to a public health authority that is authorized by law to receive reports of abuse or neglect. In addition, we may disclose your Protected Health Information if we believe that you have been a victim of abuse, neglect, or domestic violence to the governmental entity or agency authorized to; receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your Protected Health Information to a person or company required by the Food and Drug Administration to report adverse events, biologic product deviations, product defects, or problems; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose Protected Health Information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), and in certain conditions in response to a subpoena, discovery request, or other lawful process.

Notice of Information Privacy Practices

(Continued)

Law Enforcement: We may also disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include: (1) legal processes and purposes otherwise required by law, (2) limited information requests for identification and location purposes, (3) treating victims of a crime, and (4) suspicion that death has occurred as a result of criminal conduct.

Coroners, Funeral Directors, and Organ Donation: We may disclose Protected Health Information to a coroner or medical examiner for identification purposes, cause of death determinations, or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose Protected Health Information to funeral directors, as authorized by law, in order to carry out funeral-related duties. We may disclose such information in reasonable anticipation of death. Protected Health Information may be used and disclosed for cadaveric organ, eye, or tissue donation purposes.

Research: We may disclose your Protected Health Information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your Protected Health Information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your Protected Health Information if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose Protected Health Information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose Protected Health Information of individuals who are Armed Forces personnel for: (1) activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your Protected Health Information to authorized federal officials for conducting national security and intelligence activities, including the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your Protected Health Information as authorized to comply with workers compensation laws and other similar legally established programs.

Inmates: We may use or disclose your Protected Health Information if you are an inmate of a correctional facility and your physician created or received your Protected Health Information in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements of 45 CFR, Title II, Section 164, et. seq.

YOUR RIGHTS - You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records but does not include psychotherapy notes. To inspect and copy your medical information, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy & Security Office at the address on the top of this Notice. If you request a copy of information, we may charge a fee for the cost of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request the denial be reviewed. For more information call (402) 471-8417.

Right to Amend. If you feel that medical information about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for DHHS. To request an Amendment, your request must be made in writing at the Site of Service or submitted to the State of Nebraska, Health and Human Services, HIPAA Privacy & Security Office at the address on the top right of this Notice. In addition you must provide a reason which supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for DHHS;
- Is not part of the information which you would be permitted to inspect and copy; or,
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list, you must submit your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy & Security Office address on the top of this Notice. Your request must state a time period for the disclosures, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list to be provided to you: for example, on paper, or by e-mail.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you can ask that we not use or disclose information about a surgery you had performed.

We are not required to agree to your request for restrictions. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy & Security Office at the address on the top of this Notice. In your request you must tell us: (1) what information you want to limit, (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply; for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing at the Site of Service, or to the State of Nebraska, Department of Health and Human Services, HIPAA Privacy & Security Office at the address on the top right of this form. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You may obtain a copy of this notice at our website, <http://www.dhhs.state.ne.us>. To obtain a paper copy of this notice, call (402) 471-8417 during regular working hours.

COMPLAINTS - If you believe your privacy rights have been violated, you may file a complaint with DHHS or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with DHHS, you may contact our Privacy Contact, DHHS HIPAA Privacy & Security Office at (402) 471-8417 Monday through Friday from 9:00 a.m. to 4:30 p.m., except State holidays, or hipaa.office@dhhs.state.ne.us for further information about the complaint process. To file a complaint with HHS, contact: Secretary, Health and Human Services, Office of Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201, 1-866-OCR-PRIV (627-7748), 1-866-778-4989-TTY. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION - If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we provided you.

Changes to the Notice of Information Practices - The State of Nebraska Health and Human Services reserves the right to amend this Notice at any time in the future. Until such amendment is made, DHHS is required by law to abide by the terms of this Notice.

Informed Consent and Release of Medical Information

1. Read this page.
2. Keep this page for your records.

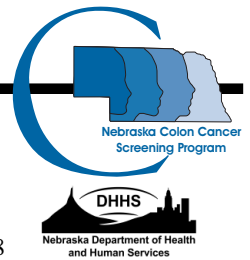
Version: August 2008

- I want to be a part of the Nebraska Colon Cancer Screening Program (NCP). I understand that I must be 50 years of age or older and fall within the income guidelines in order to be eligible for enrollment. I also understand that I need to complete an enrollment form every year in order to participate in the NCP.
- If I am under 50 years of age, I know I **cannot** be a part of the NCP (*there are no exceptions*).
- I understand that the NCP will look at my health history and tell me what colon cancer screening test is best for me if I am eligible to participate.
- Based on my health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to NCP, I will not get reminders about screening.
- Based upon my health history and what type of test is best for me, I know that the NCP may provide me with a Fecal Occult Blood Test (FOBT) kit and/or assist me in scheduling a colonoscopy. If I am enrolled in the program and receive an FOBT from the program and have a positive test, it may be followed up with a colonoscopy.
 - If I receive a colonoscopy through the NCP I understand that I will be asked to pay 10% of the cost.
 - I understand that my payments will help others with colonoscopy costs through the NCP.
- I have talked with my healthcare provider about the screening test(s) and understand possible side effects or discomforts.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by the NCP.
- I understand that the NCP does not pay for treatment if diagnosed with colon cancer. NCP staff will assist me in finding the most appropriate treatment resources.
- My doctor, laboratory, clinic, radiology unit, and/or hospital can give the results of my colorectal screening, diagnostic tests, and/or treatment services to the NCP.
- To assist me in making the best healthcare decisions, NCP may share clinical and other healthcare information including lab results and health history with my healthcare providers.
- I understand that I need to identify a primary care doctor on my form. The NCP may follow up with my primary care doctor if my past medical records need to be reviewed to determine the best colon cancer screening for me. I accept responsibility for following through on any advice my doctor may give me.
- My name, address, and/or other personal information will be used only by the NCP. It may be used to let me know when I need follow up exams. This information may be shared with other organizations as required to locate treatment resources.
- Other information may be used for studies approved by the NCP and/or The Centers for Disease Control and Prevention (CDC) for use by outside researchers to learn more about colon health. These studies will not use my name or personal information.

Nebraska Health and Human Services System - Nebraska Colon Cancer Screening Program
301 Centennial Mall South, P.O. Box 94817 - Lincoln, NE 68509-4817
1-800-532-2227 - Fax: 1-402-471-0913

Funds for this project were provided through the Centers for Disease Control and Prevention Breast and Cervical Early Detection Program, Well Integrated Screening and Evaluation for Women Across the Nation, and Colorectal Cancer Screening Demonstration Program Cooperative Agreements with the Nebraska Department of Health and Human Services System. #U58/DP000811, #U58/DP001421 and #3U55DP725047

Enrollment Form for Men & Women 50+



1. **ALL QUESTIONS MUST BE ANSWERED.** Please print. Fill in as much as possible.
2. **Read and Sign the back of this page.**
3. **Return this form to the Nebraska Colon Cancer Screening Program.**

Version August 2008

First Name		Initial	Last Name		Maiden Name <i>(if applicable)</i>	
Birthdate month / day / year		Age	Gender M / F	Social Security #		
Address			City	County	State	Zip
Home/Cell Phone <i>circle one</i> ()		Work Phone ()		How did you hear about the program? <input type="checkbox"/> Doctor <input type="checkbox"/> Other healthcare provider <input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Magazine <input type="checkbox"/> Newspaper <input type="checkbox"/> Billboard <input type="checkbox"/> Website <input type="checkbox"/> Mailing/Flyer <input type="checkbox"/> EWM Program <input type="checkbox"/> Community Event <input type="checkbox"/> Other _____		
Contact person: _____ <i>(in case we can't reach you)</i> Relationship: _____ Phone: () _____ Address: _____ City: _____ State: _____ Zip: _____				Are you of Hispanic/Latina/Latino origin? <input type="checkbox"/> Yes <input type="checkbox"/> No Country of origin _____ What is your primary language? <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____		
What race or ethnicity are you? <input type="checkbox"/> American Indian <input type="checkbox"/> Black/African American <input type="checkbox"/> Mexican American <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other _____				Highest grade in school you completed: <i>circle one</i> 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+		
<i>I will be required to show proof that my income is within the NCP income guidelines when I am contacted by the NCP staff. If I am found to be over the income guidelines, I will be responsible for my bills.</i>						
What is your household income before taxes? Yearly Income: \$ _____				How many people live on this income? _____		
Do you have: <input type="checkbox"/> Medicare Part A and B <input type="checkbox"/> Medicare Part A only <input type="checkbox"/> Medicaid (full coverage for self) <input type="checkbox"/> None/No Coverage <input type="checkbox"/> Private Insurance with or without Medicaid Supplement <i>(please list)</i> _____						
Is your insurance an HMO? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>An HMO is a health maintenance organization.</i>						
Family History: How many 1st degree relatives, excluding yourself, <i>(parents, brothers, sisters, children)</i> have been told they have colon cancer or rectal cancer? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ <input type="checkbox"/> Don't Know How many of those family members with colon cancer were under the age of 60? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ <input type="checkbox"/> Don't Know How many 1st degree relatives, excluding yourself, <i>(parents, brothers, sisters, children)</i> have been told they have polyps in the colon? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ <input type="checkbox"/> Don't Know How many of those family members with polyps were under the age of 50? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ <input type="checkbox"/> Don't Know How many 1st degree relatives, excluding yourself, <i>(parents, brothers, sisters, children)</i> have been told they have other types of cancer? <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3+ <input type="checkbox"/> Don't Know What kind of cancer did they have? _____				Personal History: Have you ever had any of the following tests?: Fecal Occult Blood Test (FOBT) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Date ____/____/____ What did your doctor say about your exam? _____ Was your exam: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Colonoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Date ____/____/____ What did your doctor say about your exam? _____ Were there polyps removed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Sigmoidoscopy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Date ____/____/____ What did your doctor say about your exam? _____ Were there polyps removed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Double Contrast Barium Enema (DCBE) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know Date ____/____/____ What did your doctor say about your exam? _____		

MUST COMPLETE AND SIGN BACK ➡➡➡➡

Mailing Address: Nebraska Colon Cancer Screening Program -301 Centennial Mall South, P.O. Box 94817-Lincoln, NE 68509-4817

Nebraska Colon Cancer Screening Program Enrollment Form *(continued)*

Personal History: *(continued)*

Have you ever been told by a doctor, nurse, or other health professional that you have had:

Crohns Disease

☐ Yes ☐ No ☐ Don't Know

Familial Adenomatous Polyposis (FAP)

☐ Yes ☐ No ☐ Don't Know

Hereditary Non Polyposis Colorectal Cancer (HNPCC)

☐ Yes ☐ No ☐ Don't Know

Inflammatory Bowel Disease (IBD)

☐ Yes ☐ No ☐ Don't Know

Ulcerative Colitis

☐ Yes ☐ No ☐ Don't Know

Are you currently under a doctor's care for any of the above conditions?

☐ Yes ☐ No ☐ Don't Know

Within the last **30 days** have you had bleeding from the rectum?

☐ Yes ☐ No ☐ Don't Know

What did your doctor say about your rectal bleeding? _____

Have you ever been told that you have had polyps in the colon?

☐ Yes ☐ No ☐ Don't Know

What type of polyps did you have? _____

How many polyps did you have? _____

Have you ever been told you have had colon or rectal cancer?

☐ Yes ☐ No ☐ Don't Know

If yes, when were you diagnosed? ____/____/____

Please tell us who your primary care doctor is (name of doctor): _____

Name of clinic: _____ City: _____ Phone: _____

- I want to be a part of the Nebraska Colon Cancer Screening Program (NCP). I understand that I must be 50 years of age or older and fall within the income guidelines in order to be eligible for enrollment. I also understand that I need to complete an enrollment form every year in order to participate in the NCP.
- If I am under 50 years of age, I know I **cannot** be a part of the NCP (*there are no exceptions*).
- I understand that the NCP will look at my health history and tell me what colon cancer screening test is best for me if I am eligible to participate.
- Based on my health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to NCP, I will not get reminders about screening.
- Based upon my health history and what type of test is best for me, I know that the NCP may provide me with a Fecal Occult Blood Test (FOBT) kit and/or assist me in scheduling a colonoscopy. If I am enrolled in the program and receive an FOBT from the program and have a positive test, it may be followed up with a colonoscopy.
 - If I receive a colonoscopy through the NCP I understand that I will be asked to pay 10% of the cost.
 - I understand that my payments will help others with colonoscopy costs through the NCP.
- I have talked with my healthcare provider about the screening test(s) and understand possible side effects or discomforts.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by the NCP.
- I understand that the NCP does not pay for treatment if diagnosed with colon cancer. NCP staff will assist me in finding the most appropriate treatment resources.
- My doctor, laboratory, clinic, radiology unit, and/or hospital can give the results of my colorectal screening, diagnostic tests, and/or treatment services to the NCP.
- To assist me in making the best healthcare decisions, NCP may share clinical and other healthcare information including lab results and health history with my healthcare providers.
- I understand that I need to identify a primary care doctor on my form. The NCP may follow up with my primary care doctor if my past medical records need to be reviewed to determine the best colon cancer screening for me. I accept responsibility for following through on any advice my doctor may give me.
- My name, address, and/or other personal information will be used only by the NCP. It may be used to let me know when I need follow up exams. This information may be shared with other organizations as required to locate treatment resources.
- Other information may be used for studies approved by the NCP and/or The Centers for Disease Control and Prevention (CDC) for use by outside researchers to learn more about colon health. These studies will not use my name or personal information.

Signature

Date of Signature

Please Print Name

Date of Birth